



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COMBINED CHIROPRACTIC SERVICES & REHAB INC
PO BOX 700311
SAN ANTONIO TEXAS 78270

Respondent Name

PACIFIC INDEMNITY CO

Carrier's Austin Representative

Box Number 17

MFDR Tracking Number

M4-13-3270-01

MFDR Date Received

August 12, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient was seen in my office for a doctor to patient assessment for any question that the patient may have. This is not a duplicate the patient sees me for pain management the evaluation of the patient...The patient has a lot of DOS that were already paid and this [sic] are the only that have not been paid for. Included you will find all HICFs' [sic] and proper documentation for the services render [sic] to the patient. The service performed was an office visit for evaluation new or established patient..."

Amount in Dispute: \$665.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The DWC-60 from the Requestor lists the dispute as a fee dispute and involves office visits for the dates of service 11/4/11-4/23/12. Respondent contends that this request for Medical Fee Dispute Resolution should be immediately dismissed based on Requestor's failure to timely file its dispute within one year of the date of service as required by DWC Rule 133.307(c)(1)(A)."

Response Submitted by: Downs & Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 4, 2011 through April 23, 2012	99213	\$665.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- T13 – Med necessity denial. Appeal within 11 mos of DOS
- 074 – Denied per IME
- 50 – Service not Deemed 'Medical Necessary' by payer
- R01 – Duplicate billing
- B13 – Payment for service may have been previously paid
- 193 – Original payment decision maintained

Issue

1. Did the requestor waive the right to medical fee dispute resolution?
2. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
3. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. 28 Texas Administrative Code §133.307(c) (1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the services in dispute are November 4, 2011 through April 23, 2012. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on August 12, 2013. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.
2. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."

28 Texas Administrative Code §133.307(e) (3) (G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General).

The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution.
3. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute.

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	September 27, 2013 Date
--------------------	---	----------------------------

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.